Civilian Student Training Program

Special Power of Attorney for Medical Care and Custody of Child

Know all men by these presents:

That I, _____the parent/guardian of _____, a minor child enrolled in the Arkansas Department of Human Services (Division of Youth Services) Civilian Student Training Program (CSTP), held at Camp Joseph T. Robinson, do hereby make, **Millicent Booth** as my true and lawful attorney-in-fact with full and complete power to authorize and provide for

1. the care, custody, control, discipline, maintenance, well-being, education and health of my child/ward related to participation in CSTP, including even major surgery if deemed necessary by a duly licensed physician;

2. whenever medical treatment services related to participation in CSTP are necessary for the care of my minor child/ward named above;

3. to sign in my name, place and steed on any document whatsoever necessary under the law, and

4. to make, sign, endorse, act, receive or accept any instrument of any kind or nature as may be necessary or proper in the furtherance of any of the above enumerated powers.

I hereby declare, that unless sooner terminated by me, all powers granted herein to my attorney-in-fact shall terminate on the date and time of notification to me of my child/ward's discharge, whether voluntary or involuntary, from the Civilian Student Training Program.

In the event that Millicent Booth is unavailable or unable to serve as my true and lawful attorney-in-fact, I hereby make **Stella Phillips** my true and lawful attorney-in-fact with the full and complete powers listed above.

The attorney-in-fact will serve without compensation.

_____

(Parent/Guardian Signature)

ACKNOWLEDGEMENT

STATE OF ARKANSAS

County of _____

I, the undersigned, do certify that on this date personally appeared before me, _____, who being sworn, subscribed his or her name to this instrument and acknowledged to me that it was his or her voluntary act and deed.

IN WITNESS WHEREOF, I have here unto set me my hand and affixed my official seal on this _____ day of _____

_____ Notary Public

My commission expires on : _____

Civilian Student Training Program

Consent to Participation

I hereby consent to my child's (_____) participation in the **Civilian Student Training Program (CSTP**), and that my child/ward may participate in the activities of such program including physical training programs, transportation in motor vehicles, work activities, and other activities which may, in the normal course of events, cause injury; understanding that the CSTP Staff Members will exercise reasonable care to prevent injury or illnesses, but that such activities may result in injury or illnesses, and that I hereby assume such risks as the parent, natural guardian, or legal guardian of said child.

I understand that neither the State of Arkansas nor the United States, or any of their agencies, employees, agents or officers in any way agree to liability for the expense of medical care either as insurer or by contract, and that I remain liable for the costs of medical care of my child/ward as though I had consented to such medical care and services in person.

_____

(Parent/Guardian Signature)

ACKNOWLEDGEMENT
STATE OF ARKANSAS

County of_____

I, the undersigned, do certify that on this date personally appeared before me, _____, who being sworn, subscribed his or her name to this instrument and acknowledged to me that it was his or her voluntary act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal on this _____ day of_____
_____Notary Public

My commission expires on:_____

DRUG AND ALCOHOL TESTING AUTHORIZATION

I,_____, parent/guardian of _____
give my permission/authorization for the Civilian Student Training Program (CSTP) to conduct a Drug and/or Alcohol Test on my child at time/times deemed necessary by CSTP policy or personnel: to include random drug screens or for-cause drug screens. I understand that the results of these tests are confidential and will only be released as required by Arkansas law, Court Order or CSTP policy.

_____ _____
(Parent/Guardian Signature) Date

MEDICATION AUTHORIZATION

I,_____, give my permission for over-the-counter medicines and/or medicines prescribed by a physician, to be administered to _____
by the designated CSTP personnel.

_____ _____
(Parent/Guardian Signature) Date

CIVILIAN STUDENT TRAINING PROGRAM MEDICAL DISCLOSURE

Student Name: _____

Does the student have allergies? ___ Yes ___ No

If yes, list the allergies:

Does the student have an Epipen for allergic reactions? ___ Yes ___ No

Does the student have asthma? ___ Yes ___ No

If yes, does the student use an inhaler? ___ Yes ___ No

Has the student ever had to stay in a hospital or behavioral center? ___ Yes ___ No

If Yes, Where? When? Why?

Does the student do therapy or counseling? ___ Yes ___ No

If yes, with what service or therapist?

Is the student taking medication? ___ Yes ___ No

If yes, what is the name and dosage medication?

What is the medication for?

**Note: this medication/dosage/reason must be listed on the student's Physical form.

Is the student prescribed any medications that he is NOT taking? ___ Yes ___ No

If yes, what is the name of the medication?

Do you want your student to take melatonin to help with sleep? ___ Yes ___ No

Does the student use a sleep apnea machine? ___ Yes ___ No

All Personally Identifiable Information Herein is Protected by the Privacy Act and HIPAA.

Has the student ever had broken bones? ___ Yes ___ No

If yes, please describe:

Has the student ever had a seizure? ___ Yes ___ No

If yes, when?

Has the student ever had any surgery? ___ Yes ___ No

If yes, please describe:

Does the student wear glasses or contacts? ___ Yes ___ No

Does the student have any dental problems that need attention? ___ Yes ___ No

If yes, please describe:

We need your **insurance information** in case your student needs medical treatment or medication while at CSTP. Please give your probation officer a copy of your Insurance Card. We need to make sure we have the following information:

Insurance Name:
Insurance Number:
Pharmacy Information:

- RxBIN:
- RxPCN:
- RxGroup:

PASSE# (if the student is in one with Total Care, Empower, Summit, CareSource):

- Name of Care Coordinator:
- Care Coordinator's Phone number:
- Expiration Date:
  - THIS INFORMATION IS ON PASSE INSURANCE CARD.
  - If you're not sure, call 1-844-809-9538

Parent/Guardian Signature: _____ Date: _____

STUDENT EMERGENCY CONTACT INFORMATION

All Personally Identifiable Information Below Is Protected by the Privacy Act and HIPAA.

Student First / Middle / Last Name_____

Student Social Security Number_____

Student Date of Birth_____

PRIMARY EMERGENCY NOTIFICATION

Parent/Guardian's Name:_____

Home Phone:_____ Work Phone:_____Cell Phone:_____

Home Address:_____City:_____ Zip:_____

Email Address:_____

ALTERNATE EMERGENCY NOTIFICATION

Name: _____ Relationship:_____

Address/City: _____ Phone #:_____

MEDICAL PROVIDER INFORMATION

Student's Doctor: _____ Doctor's Phone #:_____

Insurance/Medicaid/ARKids:_____ Policy #:_____

Probation Officer: _____ Phone #:_____

AUTHORIZATION FOR RELEASE OF INFORMATION TO DIVISION OF YOUTH SERVICES (DYS)

CIVILIAN STUDENT TRAINING PROGRAM (CSTP)
Camp J. T. Robinson, North Little Rock, AR 72199
Telephone: 501-534-3170/501-534-3171

I hereby authorize the release of information to the above address such information that appears appropriate from any physician, hospital, school, clinic, counselor, psychiatrist, or institution having medical, psychological, school records, and/or social records concerning:

_____
Juvenile's full legal name

_____
Juvenile's date of birth

_____
Juvenile's social security number

I understand that this information will be used by the staff of the Division of Youth Services (DYS) – CSTP to determine what services are available to help my child. A photographic copy of this information shall be as valid as the original.

_____ _____
Parent/Guardian Date

LEGAL STATUS TO THE ABOVE JUVENILE: (circle one) Mother Father Other_____

_____
Print name above

_____
Address

_____
City, State, ZIP

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Image & Story Consent Form

I authorized the Arkansas Department of Human Services (DHS) Office of Communications to use my image in still photography or video and/or my story for a news release, publicity, outreach and education about a DHS program, service or law.

This authorizes the use of my image for public outreach and education materials both printed and online as well as the release of materials to state and local officials and the news media, and includes organizations responsible for printed publications such as newspapers, magazines, journals, etc. as well as organizations that provide information to the public though electronic media such as TV, radio, social media, etc.

_____

(Name) Student

_____

(Address)

_____

(Phone number and email address)

_____

(Signature) Parent/Guardian

_____

(Date)

Civilian Student Training Program
GED Program Participation Permission

I,_____(parent/guardian) give_____(student) permission to enroll in an adult education program in order to pursue an Arkansas High School Diploma through the General Education Development (GED) program.

Student must be 16 or 17 years old to participate in the GED program.

Student's Name:_____ SSN:_____

Current Address:_____
(Street/PO Box) (City) (State) (Zip Code)

Date of Birth: _____ Age:_____ Telephone #:_____

Last School Attended:_____ Current Grade:_____

_____ _____
Parent/Guardian Signature Date

_____ _____
CSTP GED Teacher Signature Date